

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22628

STATE FILE NUMBER

Registration District No. 372

Primary Registration District No. 4543

Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>WEBSTER CO</u>				2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Webster</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Yes <input type="checkbox"/> No <input type="checkbox"/> TOWN <u>Seymour MO</u>				c. CITY OR TOWN <u>Seymour 1120</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If outside, give location) Reside on Farm <u>MO</u> Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA MAY McNEALY</u>				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1884</u>	9. AGE (In years 1 day 1 day)	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (City and state or country) <u>GATES CENTER KANSAS</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>BENJAMIN PHUTCHINS</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA R. NAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Chester McNealey Seymour MO</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Cerebral Vascular spasm</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart disease, coronary heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>2 days</u> <u>16 years</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>20 May 56</u> to <u>22 June 56</u> and last saw her alive on <u>9 June 56</u> Death occurred at <u>10 15</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. M. Macdonnell MD</u>				22b. ADDRESS <u>Marshfield, Mo.</u>		22c. DATE SIGNED <u>27 June 56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6-25-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		23d. LOCATION (City, town or county) (State) <u>Springfield, MO</u>	
24. FUNERAL DIRECTOR <u>Robert Bergman Seymour MO</u>				25. DATE RECD. BY LOCAL REG. <u>6-30-1956</u>		26. REGISTRAR SIGNATURE <u>Gilbert Jones</u>	

(Licensed Embalmer's Statement on Reverse Side)

343
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MAY 15 1959

JAN 12 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....*Max L Miller*

Licensed Embalmer No. *47*

P. O. Address *Manassas*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.